Arkansas State Board of Pharmacy
101 East Capitol, Suite 218
Little Rock, AR 72201
501-682-0190
http://www.state.ar.us/asbp

Application for a Graduate Intern Training Plan

Please note: You must have a *Graduate Intern Training Plan* on file at the Board of Pharmacy to work as a graduate intern. A *Buff Card* will be sent to the pharmacy listed on this *Graduate Intern Training Plan* to allow you to work with limited supervision in a Class A pharmacy. Do not work until the pharmacy has received the *Buff Card*.

(Please print or type)

NAME: Last First Middle	Intern License #	For office use only Date Received:_____ Processed by:_____
HOME ADDRESS: Number Street		
City State Zip		
MAILING ADDRESS: If different from above, indicate your mailing address:		
Home Telephone Number ( )	Daytime Telephone Number ( )	
Academic classification (check one) P2 ___ P3 ___ P4 ___ Graduate___	Social Security Number	
Type of practice Community/Retail…..___ Hospital……..___ Research……___ Other ……..___	If you checked "other", please describe here.	
Pharmacy Name	Pharmacy Permit #	
Pharmacy Address _____ number and street _____ city, state, zip	Pharmacy Phone Number ( ) Pharmacy Fax Number ( )	

(Please print)
Name of Graduate Intern Pharmacist_____
First Middle Last

Employment: I will be employed for _____ hours per week as follows:

Monday	From_____	To_____
Tuesday	From_____	To_____
Wednesday	From_____	To_____
Thursday	From_____	To_____
Friday	From_____	To_____
Saturday	From_____	To_____
Sunday	From_____	To_____
Part-Time Relief	I will be employed approximately _____ hours per week.	

Intern Agreement: *Please carefully read and sign below.*

I understand that, as a graduate intern, I must be in at least telephone contact with a licensed pharmacist at all time that I am performing any functions that are defined as the practice of pharmacy.

I further understand that I must have a *Graduate Intern Training Plan* on file at the Board of Pharmacy in order to receive credit for experience hours. A *Buff Card* will be sent to the pharmacy where I plan to gain pharmacy experience hours. I cannot work until the pharmacy has received the *Buff Card*.

I must submit a record of my graduate intern experience on the *Affidavit of Experience*, if I expect to receive credit for such experience toward completion of my experience requirement.

I understand that falsification of the information on this form may constitute grounds for denial or revocation of the registration. I hereby certify under penalty of perjury under the laws of the State of Arkansas to the truth and accuracy of all statements and representations made in this application and that I personally completed the application. I understand that I must notify the Board in writing of any change of address during my internship. I have read and understand the instructions and statements on this application.

_____ _____
Signature of intern pharmacist Date signed

Pharmacy Supervisor Agreement:

I accept the responsibility to personally supervise at all times within voice or telephone contact

_____, a graduate intern pharmacist, or to arrange for another
(please print the graduate intern's name)
pharmacist to represent me.

Pharmacy Supervisor's Name _____ License #_____ Date_____
(please print)

Pharmacy Supervisor's Signature_____